

Previous Traumatic Life Events versus Course and Effectiveness of PTSD Therapy in Veterans of Polish Military Contingents

Maciej Zbyszewski, MS

Sylwia Szymanska, MS

Col. (Ret.) Stanisław Ilnicki MD, PhD

Military Medical Institute,
Department of Psychiatry and Combat Stress
ul.Szaserow 128
04-141 Warszawa
POLAND

E-mail: maciekbyszewski@yahoo.com; ilnickis@wim.mil.pl

ABSTRACT

The goal of the paper is to show that an impasse in PTSD therapy in veterans of combat missions abroad may be connected with the occurrence of previous traumatic events. Symptoms that originally seemed to be those resulting from a war trauma, actually had had their source in personalities of the patients and their previous traumatic experiences, not related to combat stress. Identification, analysis and further processing of those events within the therapy resulted in a breakthrough in the therapy and allowed for further successful work on the PTSD symptoms. Special attention was paid to, among other things, problems of a sexual trauma, attachment trauma and personality disorders in soldiers with PTSD symptoms.

Key words: PTSD, sexual trauma, attachment trauma, personality disorders, psychotherapy.

1.0 INTRODUCTION

After several years of experience with veterans of Polish Military Contingents admitted to the Clinic of Psychiatry and Combat Stress due to post-traumatic stress disorder we have observed a distinct phenomenon. It turned out that the course of therapy and treatment of the patients has various patterns. In some patients PTSD symptoms abate spontaneously while in other ones they take the form of a PTSD syndrome resistant to both medication and psychotherapy. What is the driver for this difference in the healing process? Analysing particular cases we decided to take a look at the history of each veteran, reaching deep into his past, a long time before he had any contact with war. As Schnurr writes: in order to understand PTSD aetiology well, it should be taken into account what is being brought into a traumatic situation by an individual and what he experiences later; an analysis of the traumatic event alone is not enough. [1]

Because of this we were wandering how and to what extent previous life events affect the manner of living through a war trauma. The analysis has shown that, among various life events, especially previous traumatic experiences may affect the arduousness of currently experienced combat stress symptoms. A history of traumatic events within a lifespan shows they are mutually connected. It can be even stated that there is a continuity of trauma in human life, from infancy to adulthood, as every trauma imprints its

Report Documentation Page				Form Approved OMB No. 0704-0188	
Public reporting burden for the collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to Washington Headquarters Services, Directorate for Information Operations and Reports, 1215 Jefferson Davis Highway, Suite 1204, Arlington VA 22202-4302. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to a penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.					
1. REPORT DATE APR 2011		2. REPORT TYPE N/A		3. DATES COVERED -	
4. TITLE AND SUBTITLE Previous Traumatic Life Events versus Course and Effectiveness of PTSD Therapy in Veterans of Polish Military Contingents				5a. CONTRACT NUMBER	
				5b. GRANT NUMBER	
				5c. PROGRAM ELEMENT NUMBER	
6. AUTHOR(S)				5d. PROJECT NUMBER	
				5e. TASK NUMBER	
				5f. WORK UNIT NUMBER	
7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES) Military Medical Institute, Department of Psychiatry and Combat Stress ul.Szaserow 128 04-141 Warszawa Poland				8. PERFORMING ORGANIZATION REPORT NUMBER	
9. SPONSORING/MONITORING AGENCY NAME(S) AND ADDRESS(ES)				10. SPONSOR/MONITOR'S ACRONYM(S)	
				11. SPONSOR/MONITOR'S REPORT NUMBER(S)	
12. DISTRIBUTION/AVAILABILITY STATEMENT Approved for public release, distribution unlimited					
13. SUPPLEMENTARY NOTES See also ADA578905. Mental Health and Well-Being across the Military Spectrum (Bien-être et santé mentale dans le milieu militaire). RTO-MP-HFM-205					
14. ABSTRACT The goal of the paper is to show that an impasse in PTSD therapy in veterans of combat missions abroad may be connected with the occurrence of previous traumatic events. Symptoms that originally seemed to be those resulting from a war trauma, actually had had their source in personalities of the patients and their previous traumatic experiences, not related to combat stress. Identification, analysis and further processing of those events within the therapy resulted in a breakthrough in the therapy and allowed for further successful work on the PTSD symptoms. Special attention was paid to, among other things, problems of a sexual trauma, attachment trauma and personality disorders in soldiers with PTSD symptoms					
15. SUBJECT TERMS					
16. SECURITY CLASSIFICATION OF:			17. LIMITATION OF ABSTRACT SAR	18. NUMBER OF PAGES 12	19a. NAME OF RESPONSIBLE PERSON
a. REPORT unclassified	b. ABSTRACT unclassified	c. THIS PAGE unclassified			

significant mark on the personality of an individual. [2] This way an individual, experiencing another trauma, has to cope with it, having a burden of previous traumas and defence mechanisms generated by them. In this context, we wanted to take a look in this paper into a war trauma as a „scar” caused by previously experienced traumas. To be precise, we wanted to show that difficulties in the course of the therapeutic process of PTSD patients originate from previous traumatic experiences. A trauma being experienced in the present time is linked to difficult relations and events from the past, it revives all, buried issues that had been put under control to some extent. [3] We will present our data by means of an analysis of five cases of soldiers - veterans of war missions deployed to Iraq, Afghanistan and the Balkans, hospitalised in the Clinic of Psychiatry and Combat Stress of the Military Institute of Medicine in Warsaw in the period of 2006 - 2009.

The description of five patients' histories is presented below in a structured way. First we present a brief description of hospitalisation in the Clinic of Psychiatry and Combat Stress including the admission diagnosis, medication and mental state of the patients upon admission. Next we present the traumatic event experienced by each patient and then describe characteristic symptoms observed, highlighting their intensity or effect and importance for the treatment. In the further part we focus on describing the five histories from the perspective of the whole process of psychological therapy, starting with presenting the nature of the stalemate in therapy of each patient. Next we describe the discovery of what within the therapy had a fundamental effect on results of the therapy, visible as improvement of functioning and mental health of the patients.

2.0 CASE STUDIES

2.1 Bernard: Superego Pathology

The first case describes a 39-year old career soldier, a Military Police officer. So called Superego pathology is the key for understanding effectiveness of PTSD treatment in this case. The patient comes from a small place in the Masovia province. The mother's pregnancy and further growth of this individual was correct. He had no history of any somatic diseases. There were no cases of mental disorders in his family. His parents were farmers and the patient was their middle child. No problems occurred in his schooling process. Also his military service was uneventful. Commanders assessed Bernard as a good and dependable soldier. Currently he is divorced; however, his whole personal life situation connected with the ending his marriage - that survived more than 10 years - was quite difficult to him and it had an additional impact on his mental condition. Bernard has a 13-year old son and tries to maintain good relations with him. Currently he has been living for several years in a successful informal relation with a woman.

2.1.1 Hospitalisations

Bernard was undergoing outpatient psychiatric treatment from 2003. So far he has been hospitalised on a psychiatric ward six times. The first hospitalisation took place within 24 hours after a traumatic event (F43.0). He was obtaining an outpatient treatment in the Clinic of Psychiatry and Combat Stress in Warsaw since 2003. He was hospitalised four times with a diagnosis of mixed anxiety and depression (F41.2) including one hospitalisation in the daytime ward mode. Duration of most of the hospitalisations was 6 weeks. During his first two stays in the Clinic Bernard's attitude towards the treatment and therapy was reluctant. Only the fifth stay in hospital (in 2008) turned out to be crucial for success of his PTSD treatment. At that time he was medicated with escitalopram 30 mg/die, valproate sodium 900 mg/die.

2.1.2 Traumatic Event

In 2003, when Bernard was performing his duties during street unrest in one of cities, he fatally shot (a point-blank shot in the head) one of the chief initiators of fighting with the police. Despite this the court found him guilty of causing the man's death.

2.1.3 Symptoms

During the first two hospitalisations the patient was complaining of acute, persistent headache; in the opinion of the therapists these pains resulted from attenuation of emotions experienced. The headache did not subside even after taking powerful painkillers. The patient was trying very hard to do all his best in order to avoid talking, reminding and experiencing anything related to the traumatic event. This suppressing and avoidance caused sudden outbursts of anger. He was complaining of insomnia and if he even managed to get asleep he would dream dreams full of nightmares. In daytime Bernard experienced flashbacks of the fatal shot scenes and thought intrusions revisiting the critical event. Interestingly enough and what was very unique for understanding the patient's internal suffering, it was observed that during the group therapy sessions he would be, e.g. persistently banging his head against the wall or rubbing strongly hand against another hand until the epidermis is scraped off. In an individual contact with the psychologist the patient admitted this had been caused by the fact that sometimes he saw blood on his hands and wanted very much to remove it. Opinions of the patient on himself shown strong autodepreciation. He was calling himself "the evil of this world", "nobody", "a murderer and ruthless sadist".

2.1.4 Therapy History

During the first two hospitalisations in the Clinic the patient did not enter the therapeutic process. He was reluctant to both therapeutic and pharmaco-therapeutic actions, and avoided individual work with the psychologist. He was leaving the group therapy sessions with door slamming and vulgar comments on their sense. After therapeutic sessions he responded with a higher body temperature. However, the third hospitalisation featured the patient's full consent to undergo the therapy. In addition to everyday group therapy sessions he began an individual therapy. This time Bernard was active at the sessions and despite difficulties he felt, he presented the history of his life at the therapeutic group forum. The fourth hospitalisation was a summary and confirmation of the changes worked out within his stays in the Clinic.

2.1.5 Therapeutic Impasse

Despite the fact that the patient decided to do a therapeutic work on himself, for a long time he refused to himself consent for feeling better. This was a resistance resulting from functioning of superego because the patient perceived his suffering as a punishment for death of the man he had shot and he was binding his misery with a hope for redemption of his guilt. He was refusing an improvement of his mental condition to himself because in that situation a relief in suffering was not what he was expecting. He was saying on himself: "the biggest punishment I have inflicted on myself is that I live", „the sense of guilt and remorse makes me perform penance while I live", "I have no right to live another way, I should suffer".

This stalemate in the therapy was also demonstrated as a lack of willingness to improve the patient's current personal situation (the divorce case, struggle for contacts with his son, etc.). He was withdrawn, passive in relation to attacks from his ex-wife and convinced that („I do not deserve anything but suffering"). It appeared that the patient was bearing his pain and suffering in a conscious or unconscious hope for some higher good, perhaps atonement for some "primary" sin he brought from the past. The impression was that his good, his salvation was depending on standing the pain. This mechanism was preventing him from making another step in his therapy in order to live a happy life.

2.1.6 Discovery

The key factor for further therapy of the patient was reaching his phantasies concerning to the Self. The point was that the patient was deeply convinced he actually is a bad man. Analysis of his lifeline allowed for discovering a primal guilt mechanism due to being an unwanted and rejected child. He transformed his sense of rejection into an unconscious belief that there is something so „wrong" in him that he deserved to be rejected. The patient lived in a conviction that if he is a faultless and righteous man in his life, a „good man", this would protect him against a further sense of guilt. In this case the court's ruling sentencing him as guilty of causing a death of another person has become the factor that disturbed the Ego's defence

structure. „Many people have concealed, attenuated areas of personality, cut off from the main stream of their lives. A connection between a nature of traumatic event and the cut-off personality area often means such a person will not be able to recover the equilibrium if he/she does not re-work the fears previously pushed out to the margin of the feelings.”[4]

2.1.7 Treatment Outcome

The therapeutic actions resulted in the fact that the patient believed in the power of psychotherapy and thus allowed himself for trusting another person. It turns out that without developing a strong therapeutic link, effectiveness of all other therapeutic procedures is low. The patient understood that he might perform penance in his life in another way, without necessity to deprive himself of the right for happiness. „What is wrong in being happy” – he was asking. „If I not forgive myself, if I do not accept the fact that I will not change that, I will remain stuck in the dead point” - said he. In general, he directed himself more to experiencing his life than to waiting for his death.

2.2 Albert: Traumatic Event Memory

Another case represents a 38-year old career soldier. In the history of this patient the factor facilitating understanding previous life events of traumatic nature, significant for PTSD therapy, was the traumatic event memory itself. During his hospitalisation the soldier had had 16 years of service in Polish Armed Forces. He comes from a complete family and lives in a small place in south-west part of Poland. The patient was born after a correct pregnancy and never suffered of a somatic illness. There is no psychiatric disorder history within his family. He had three brothers; one of them was killed in a road accident and he maintains good relations with other members of his family. No problems occurred in his schooling process. He is married and has a 12-year old son. Currently the patient serves in one of large brigades in Poland.

2.2.1 Hospitalisations

Albert was using psychiatric advisory services as an outpatient since 2007. At that time he was complaining of a continuous emotional tension remaining for several months. Sleep problems, memories of the Iraq deployment were recurring in his dreams. He was permanently anxious and experienced changing moods. The patient was sent to the Clinic of Psychiatry and Combat Stress and hospitalised in the Clinic twice, for the first time in 2009, when he stayed there for one month. The patient was admitted with the diagnosis of post-traumatic stress disorder (F 43.1). Upon admission he was aware and oriented, and the contact was good. Lowered mood, balanced drive. Affect corresponding to contents being discussed. Increased manipulation anxiety. No psychotic features.

The patient was medicated with Bioxetin 20 mg/die, Pernazine 50 mg/die, Tegretol 400 mg/die. He was discharged before the end of the therapeutic process due to a violation of ward's regulations. The second hospitalisation took place two weeks after the first discharge and lasted for six weeks. The patient was admitted with diagnosis of post-traumatic stress disorder (F 43). Upon admission the patient's mood was neutral, drive was regular and affect was adjusted. He was answering questions willingly. No psychosis features. Medicated with fluoxetine 20 mg/die, carbamazepine CR 200, perazine tabl. 25 mg/die. The second hospitalisation covered full psycho-therapeutical treatment.

2.2.2 Traumatic Event

The patient was deployed within a 12-month peace-keeping mission in the area of the former Yugoslavia. What's noteworthy, this deployment took place 14 years ago. Next he was deployed twice within Polish Military Contingent to Iraq, in 2005 and 2007. He performed all his tours of duty completely and he did not seek any psychological assistance while on deployment. In Iraq the patient witnessed bombing, many shelling attacks but in his history there was not a single stressing event; he also did not experience a direct threat to either his own life or lives of his colleagues. He was recalling the Iraqi deployment as standard combat operations. The patient felt prolonged tension and stress but not so extensive to prevent him from performing his service duties.

2.2.3 Symptoms

From the admission the patient was complaining of tension and insomnia. When his sleep was pharmaceutically rectified, unbearable nightmares occurred. Despite this at the forum of the therapeutical community the patient was denying feeling bad and camouflaging his fear with laughing. After some time he admitted he had learnt how to use this mechanism earlier, during his deployment to Yugoslavia. He was complaining of an acute tensional headache.

2.2.4 Therapy History

The patient was hospitalised twice in the Clinic of Psychiatry and Combat Stress of the Military Institute of Medicine in Warsaw. Each time, in addition to medication, everyday group therapy was applied as well as weekly sessions of individual therapy. Frequency of the latter was increased to two sessions a week during the therapeutical work on processing the trauma by a gradual imaginal exposure. Initially anger and crying were the dominating patient's response. He was reluctant to speak about his deployments and events connected with them. It appeared to him (and this is pretty typical for those suffering of PTSD) that avoidance of speaking about the war trauma and re-experiencing it is the best way to forget the trauma and suppress its memories.

2.2.5 Therapeutic Impasse

As the patient developed PTSD symptoms after his deployments to Iraq, initially it appeared quite obvious to the therapeutic team that they should work on memories from combat missions in Iraq that had taken place in 2005 and 2007. However, no therapeutic effects were obtained this way - PTSD symptoms were not reduced. In addition, during his first hospitalisation the patient violated the Clinic's regulations by drinking alcohol; in the opinion of the therapists this was a form of acting-out from the therapy driven by intensity of experiences. The patient was then discharged from the Clinic prior to completion of the diagnostic and therapeutic process; he was re-admitted after two weeks.

2.2.6 Discovery

Within the individual therapeutic work during the second hospitalisation of the patient and analysis of his dreams it was discovered that symbolics, associations and affect contained in these dreams were connected with the deployment to Yugoslavia (14 years ago!). This enabled reaching the force of traumatic events that occurred at this deployment. Only then the patient described the scenes of brutal murders committed on the civilian population by local Death Squads. The memories included also brutal scenes of women being raped and whose children were killed. Unintentionally he devoted his biographical session within the group therapy to the traumatic events in Yugoslavia instead of the Iraqi deployment as it might appear in the beginning.

2.2.7 Treatment Outcome

Only a therapeutical work on the traumatic memories from Yugoslavia led to reduction of symptoms reported upon admission that were originally seen by the therapeutic team as those related to the tours of duty in Iraq.

2.3 Cezary - A Victim of Sexual Abuse

The third case describes a 36-year career soldier who during the hospitalisation was nearly 15 years in the service. In this case a significant factor for understanding the unique nature of both PTSD symptoms and treatment was a childhood sexual trauma. The patient comes from Western Poland. Both the pregnancy and childbirth were correct. Cezary suffered no severe illness in his childhood. He has two siblings. No member of his family received any psychiatric treatment. Cezary was an average student but nevertheless he moved up to the next class every year. Also his military service was uneventful. He was married twice and has no children.

2.3.1 Hospitalisations

The patient was hospitalised three times with the preliminary diagnosis of PTSD and the stay durations were: from March 5, 2007 to March 20, 2007, from January 29, 2008 to April 11, 2008 and from September 29, 2008 to January 16, 2009. Upon admission he was alert, oriented and talkative. He was frequently mentioning his deployment. Medication: paroxetine 40 mg./die, carbamazepine 800 mg/die, promazine 200 mg/die, propranolol 40 mg/die.

The patient was in a low mood and low drive, the affect was adequate to contents expressed. He was discharged from the Clinic during his first hospitalisation ahead of schedule because he had violated the regulations (alcohol abuse). Two next hospitalisations were several-month long stays in the Clinic. During each stay he was undergoing a psycho-therapeutic treatment.

2.3.2 Traumatic Event

The patient was previously deployed to Iraq (2004) and Afghanistan (2007). In Iraq his life was endangered; however, comparing to Afghanistan the deployment passed quietly. Within the Afghanistan deployment he was a driver and his duties included patrolling. One day, while escorting a convoy, the patient's commander was killed by an explosion. The vehicle driven by the patient, alternatively with the commander's one, was leading convoys. On that day the patient pulled into a filling station to refuel; unless this refuelling stop happened, his vehicle would hit the mine.

2.3.3 Symptoms

The patient was complaining of internal tension, irritability and sleep problems. He slept 2 - 3 hours a day. He would experience nightmares on falling into a trap and also recurring dream about his commander's funeral. He was impulsive and easily responded with anger. He began to be afraid of car driving although previously he liked it. He also experienced fear of closed spaces. During therapeutic sessions he was pressing the door handle to check whether the session room was locked up for sure. Having returned to Poland he also experienced adaptation problems. He wanted to leave the armed forces but did not know what kind of job he should pursue. He had bad relations with his wife as he had failed to agree his decision on application for deployment with her. He had no specific plans for the future.

2.3.4 Therapy History

The patient underwent both individual (once a week) and group therapy (everyday). He was very active within the group sessions, even effusive. He was speaking a lot about symptoms related to his deployment: fear, irritability and insomnia. He was making friends with the others.

2.3.5 Therapeutic Impasse

The therapy was long but, despite activeness of the patient, his condition was not getting any better. The patient was continuously speaking about his experiences from Afghanistan connected with the death of his commander, declaring he was not able to tackle with that. Because of his prolonged and not too effective hospitalisations it seemed to the therapeutic team that the patient was aggravating his symptoms in order to achieve some secondary benefits. At each of the stays in the hospital he was presenting the same complaints. Also other patients did not believe in those complaints. It happened that another veteran accused him of simulating a disease during the session.

2.3.6 Discovery

During the third hospitalisation the patient for the first time mentioned he had been sexually abused as a child. The abuser was his uncle who enjoyed big respect in the family. This event was concealed for years by the victim and has not been ever brought to light. Because of the uncle's position in the family the patient as a child was afraid to reveal the secret even to those closest to him. He disclosed it for the first time during the therapeutic session. The experience of sexual violation has made the patient demonstrate

tendencies to function as a victim. The sexual abuse also affected in an obvious manner his lack of trust to other people, and in particular to authorities.

2.3.7 Treatment Outcome

The effect of this discovery was not only a reduction in symptoms of tension and gradual reduction of the combat stress ones. In the patient's mind the Afghan experiences began gradually to lose their importance. Also his life energy was shifted towards current events related to his job and personal life. He began focusing on resolving his marital situation and also decided to finally leave the armed forces. He stopped perceiving himself as a victim of war.

2.4 Damian – Attachment Trauma

Another case is a history of a 25-year old career soldier. The previous traumatic event was a rejection of the patient by his mother that took place when he was a child. The patient comes from south-western Poland. He suffered of no serious illness in his childhood and there was no psychiatric treatment history within his family. He was a poor pupil and he was kept down for a year in the sixth form. He finished a vocational school and then joined the army. Damian has been 7 years in the service. He has a step brother. For 7 years he has been in a relationship with a girlfriend (fiancée).

2.4.1 Hospitalisations

The patient was hospitalised twice in the Clinic of Psychiatry and Combat Stress: from June 9 to August 29, 2008 and from September 18 to October 17, 2008. He was diagnosed with post-traumatic stress disorder. Upon admission Damian was alert and oriented. His continuous tension was visible. Depressed mood, adequate affect, balanced drive. The medication applied was as follows: mianserin hydrochloride 60 mg/die, sulpiride 100 mg/die, hydroxyzine hydrochloride 25 mg/die, propranolol 10 mg/die. In addition to medication he also underwent both individual and group psychotherapy sessions.

2.4.2 Traumatic Event

The patient was deployed to Iraq (2005) and Afghanistan (2007). Especially in Afghanistan he experienced many traumatic events. As he recalls, he lost the sense of time while being over there: *„I was lost in time while being there – I didn't know what's the day or month. Each day on deployment looks the same - one works at full steam.”* He was deployed as a gunner - his task was looking out for threats and eliminating them. He suffered minor injuries during shelling but miraculously avoided being killed: *„I was hit by three bullets from the left, 2 at the rear plate of my bulletproof vest and 1 at my side, where there was no plate. The bullet was stopped by a grenade; I still have it.”* After that event he was vomiting for two weeks as a result of the stress. Also a colleague of him was killed in Afghanistan. Moreover, Damian witnessed lynch and tortures on the civilian population: *„A lynch began. He slashed one guy with the grenade launcher and ripped off a slice of his skin from the face. People were screaming, a sound of bones being crushed with rifles could be heard. We were standing like statues. I was shaken out from this condition by the sound of the ANS's weapons being reloaded; they wanted to kill them.”*

2.4.3 Symptoms

The patient was complaining of sleep disturbances and recurring nightmarish dreams. He used to leave the Clinic on a pass for the afternoons to walk around the city for several hours in order to get tired and be able to fall asleep. High irritability and prolonged internal tension were visible in his behaviour. The tension made him use vulgar language, in particular when he was recalling his experiences on the deployment. However, he never used vulgar words in relation to other people.

The memories were very painful to the patient: *„They began slaughtering him on the pickup platform, behind my back. This also annoys me. I recall this and I have dreams about that event. I saw that. It's unbelievable that after such a long time I still see this clearly and with all details. The moon was shining brightly. I felt helplessness. I do not know whether I did not feel bigger remorse. They were beating him,*

putting him on fire and were banging his crotch with rifle butt. They were not able to keep him, so many people and they could not keep him. They crushed his nasal septum with pliers. He was howling. These memories often return at night. I wake up. I hear him howling, the sound of beating him with the weapons. My feeling is that I will never get rid of these feeling."

The symptoms being experienced resulted also in some conflicts at home. The patient was easily getting angry and this led to numerous quarrels with his fiancée. Once when she wanted to scare him he responded like in Afghanistan and pushed her hand away which resulted in bruising her.

2.4.4 Therapy History

The patient underwent both individual therapy (once a week) using the imaginal exposure method and group one (everyday). He was attending the therapeutic session regularly and pro-actively participated in them, telling about his experiences from the deployment. He was pro-active and motivated for work on himself. The patient was easily establishing contacts with the others and was a person liked by the group.

2.4.5 Therapeutic Impasse

Near the end of the first hospitalisation a significant worsening of functioning and intensification of symptoms from PTSD group occurred. This deterioration occurred in the holiday season when a shift of the therapeutic team takes place, in terms of changing both the leading physician and the psychologist-psychotherapist. At that time the patient felt disoriented and neglected. He says he felt *"like a hot potato being passed around."*

2.4.6 Discovery

Description of the existing therapeutic situation highlights the fact that the patient was abandoned by his mother when he was 13; the mother went to Greece and was not much interested in her family. Instability of the patient-physician relationship was reminding to the patient his childhood attachment trauma and this resulted in a significant deterioration of functioning. His way of perception of being deployed was also characteristic. The patient reported an occurrence of characteristically strong bond with his colleagues at deployment, expressed by the term: *"We were eating from one bowl"*. For him these relationships were replacing the bond he had not experienced at home; that was the factor intensifying his adaptation problems after return and his willingness to leave for another deployment.

2.4.7 Treatment Outcome

Discussion and reworking of the traumatic aspects of the patient's relationship with his mother resulted also in reduction of PTSD symptoms. The patient stabilised his personal life, returned to full-time military service and was qualified for another tour of duty in Afghanistan.

2.5 Eugeniusz – „False Self"

The fifth case represents a 38-year old career soldier. In the history of this patient the key to understanding the effect of previous life events of traumatic features on the course of PTSD therapy is the personality structure, understood as a false self system; this structure has been formed in the patient's childhood due to conditions unfavourable for his emotional development that occurred at that time. In this case not any specific previous traumatic event can be mentioned; however, discovery of the developed personal functioning mechanisms had a similar impact on the PTSD therapy as in the previously discussed cases. The patient was raised in a complete family, has a brother and sister and lives in a small place in south-western part of Poland. He was born from uneventful pregnancy and has never suffered from a somatic illness. There is no family history of a psychiatric treatment. He experienced no problems at school. The patient is married and has two children: a son of 17 and a 7-year old daughter.

2.5.1 Hospitalisations

Patient was hospitalised twice in the Clinic of Psychiatry and Combat Stress. He stayed in the Clinic from February 11 to March 2, 2009 and from March 16 to April 30, 2009. He was alert and oriented upon admission, and was establishing good contact. The patient was talkative and meticulous in what he was saying, labile, with a tendency for crying. Standard drive, without psychotic symptoms. Initial diagnosis: post-traumatic stress disorder. The following medication was applied: Sertagen 100 mg/d, Tegretol 400 mg/d.

During his stay in the Clinic the patient was calm in behaviour and easily established contacts with other patients. He was attending therapeutic sessions on a regular basis and was very active during the sessions. He was responding emotionally (sadness, anger), when topics referring to events during the Iraqi deployment were mentioned.

2.5.2 Traumatic Event

The patient was deployed to Iraq twice - in 2005 and 2007. He experienced many traumatic events while deployed. The most traumatic ones included a rocket explosion 50 m away from the canteen he was in and a duty on a forward post that was attacked at night by several hundreds of Iraqis. This is how he describes these two events:

„One day when I was having my lunch in the canteen (there were several hundred people over there) I heard a powerful explosion. Although the building was lined with concrete walls, a pretty powerful blow of the wind occurred in the upper part. There was an outbreak of vast panic, screams - such a typical panic, perhaps often shown in films. I didn't know what to do, where I should move to. My arms and legs went numb. This was also the case with a couple of other soldiers. We cautiously went outside and found out that 50 m away from the canteen the rocket had hit centrally the laundry and everything was ablaze.”

„And I experienced a moment of capturing a post by locals. This was at night. The division commander refused to provide support to us because they did not want to send out anybody at night and helicopters were not flying at night. And, actually, we were rescued as usual by the Americans, in the last moment. There was fear and crying, tears in my eyes, high emotions. I was there as a communications specialist to provide communication equipment. When we were told that several hundred armed Iraqis want to capture our post I decided to mine it and blow it up once I get a command, with us outside. Having seen injured soldiers before I decided I would not come back home as a disabled person - either I would survive in one piece or I would not survive at all. It is not possible to describe those emotions, to express them in words. But the thoughts were terrible”.

2.5.3 Symptoms

The patient was complaining, first of all, of outbreaks of uncontrolled crying and anger. He was crying involuntarily when other veterans were telling stories on their experiences on deployment. He was avoiding both conversations and any memories associated with the trauma. He switched TV off when war pictures, news on the mission or even situations showing a harm done to anybody. These pictures were upsetting him a lot, distracting his attention and making him clench teeth to prevent a flood of emotions. On top of this he was suffering nightmarish dreams with contents concerning helplessness and powerlessness. He dreamed he could not get out of a building, somebody chases him and he was not able to either escape or run. The symptoms experienced resulted also in the patient's alienation from the family. He was trying to discharge his emotions seeking asylum in his allotment garden where he was building a house on his own.

2.5.4 Therapy History

Eugeniusz was hospitalised twice at the Clinic of Psychiatry and Combat Stress. Each time, in addition to pharmacotherapy, he was undergoing both everyday group therapy and weekly sessions of individual therapy using the imaginal exposure method. Frequency of the latter was increased to two sessions a week. The initial dominating symptoms in the patients were those of anger, crying and avoidance. He was

reluctant to talk about his memories and he expressed hope that it would be possible to erase them completely.

2.5.5 Therapeutic Impasse

Upon establishing an emotional bondage and when the trauma area was being approached, a coming-out occurred in the form of alcohol abuse that resulted in discharging the patient from the Clinic prior to completion of the diagnostic and therapeutic process. When he was re-admitted after two weeks, causes of his resistance within both individual and group therapy were discussed.

2.5.6 Discovery

This discussion has led to a discovery of the patient's key beliefs affecting his fear of the therapeutical work. These beliefs were formed in his childhood. His household was in a difficult general and financial situation. The patient had to work since his earliest years. He was experiencing appreciation and acceptance from his parents if he was helping them at the farm. The patient has not experienced unconditional love. As a result of this he developed a belief that his value depends on being useful. Because of this he did not give the right to be weak to himself.

These experiences are in line with the mechanism of the false self system generating. False self occurs when people around want the child to be someone else than in real life. According to Johnson, this leads to prohibition of expressing true self and in this place false self is built in accordance with requirements of surrounding people. This false self is recognised as the true one and defended against trauma and disintegration. In the same it is brittle and needs a confirmation from outside. The false self system resulted in the fact that the patient could not accept the fact he had experienced fear and impotence (his legs and arms went out of control) during the traumatic event. This led to persistence of PTSD symptoms because the expression to outside was blocked due to overwhelming shame. [5]

2.5.7 Treatment Outcome

During the therapy the patient experienced acceptance from the others to his own fear of dying and disability felt upon the traumatic event. Due to this a quick reduction of the symptoms occurred and the patient was ready to focus on his current life situation.

3.0 DISCUSSION

The analysis of five cases presented above allows to conclude that effectiveness of stress disorder therapies may depend not only on effects of a stress event or current condition of the patient but also is connected with patient's history and, to be precise, with history of his previous experiences of a traumatic nature. This is so because it turns out that not always what seems to be the main traumatic event is really such an event. Every trauma has a subjective nature, behind a battlefield stress event there may be nightmares from the past that affect the way of experiencing the event and effectively block the process of healing after the trauma. Individual stimuli and events can acquire a traumatic nature, depending on significance attributed to them by the patient. And this importance depends on previous experiences that led to development of various mechanisms of getting along. A previous trauma results in developing defensive mechanisms that maintain mental equilibrium until a current traumatic event occurs. This current experience destroys this equilibrium, resulting in a significant increase in intensity of the trauma being experienced. A similar situation is described by Khan presenting the trauma accumulation phenomenon. According to him: *„the microtraumas operate and build up silently throughout childhood right up to adolescence. They may be „muted into obedience”, the individual may arrive at a fairly healthy and effective normal functioning, nevertheless he can in later life break down as a result of acute stress and crisis”*. [6]

We also wanted to show in our paper that the treatment and therapy in such cases depend on an individual approach to the patient and understanding of the subject nature of his experiences. In order to make this possible it is also crucial to establish adequate therapeutic bondage allowing the patient to open the door to his very intimate world of painful experiences.

4.0 REFERENCES

- [1] Schnurr, PP, Friedman, MJ. *An overview of research findings on the nature of the posttraumatic stress disorder*. In Session: *Psychoterapy in Practice* 1997; 3 s. 11-25
- [2] Foa, E.B, Keane, T. M& Friedman, M. J. (2000) *Effective Treatment for PTSD; Practice Guideliness from the International Society of Traumatic Stress Studies*. New York. Guilford Press
- [3] Haley, S.A. (1974) *When the patient reports atrocities*. Archives of General Psychiatry, 30
- [4] Garland, C. (1998). *Understanding trauma. Psychonalaitical Approach*. London. Duckworth
- [5] Johnson S.M.(1994). *Charakter Styles*. New York. W. W Norton
- [6] Khan, M. M. R. (1963) *The Concept of Cumulative Trauma*. W: *The Privacy of the Self* (1974) London. Hogarth Press

